Level 6, 10 Bridge St, Sydney NSW 2000
(02) 9252 2825
www.quayhealth.com.au

ACUPUNCTURE HISTORY AND INFORMED CONSENT

ABOUT YOU

Name: Date:

Preferred Name: Date of Birth:

Address:

Postcode:

Phone (H): Mobile: (W):

Email:

Sex: Male ☐ Female ☐

Relationship Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Children (# of):

Emergency Contact: Relationship: Phone:

Occupation: Type of Work:

Have you had previous chiropractic care?: Yes ☐ No ☐ Duration of care:

Name/location of current GP:

Health Fund:

Who may we thank for referring you?:

YOUR LIFESTYLE HABITS:

Do you smoke?	Yes	☐	No	☐	If yes, how many cigarettes? ____________________________
Have you ever smoked?	Yes	☐	No	☐	If yes, when you start/give up? __________________________
Do you drink alcohol?	Yes	☐	No	☐	If yes, how much per week? ____________________________
Do you exercise?	Yes	☐	No	☐	If yes, how much do you exercise per week? ______________ ___________________________________
Do you have a balanced diet?	Yes	☐	No	☐	Details: ____
Do you have any allergies/sensitivities?	Yes	☐	No	☐	Include food, drugs/medications, herbs and vitamins:____
Do you have a history of current or past infectious disease?	Yes	☐	No	☐	Details:____
Have you had any surgery as an adult?	Yes	☐	No	☐	Details: ____
Are you currently taking any medication?	Yes	☐	No	☐	If yes, what? When did you start? ______________________
Are you currently taking any supplements?	Yes	☐	No	☐	Yes, please list: _____________________________________ ____
Have you had physical trauma as an adult?	Yes	☐	No	☐	Yes, provide details: __________________________________ ____

Main Complaint

Please identify your major health concerns

1. ____
   ____
   How long have you had this problem?____
2. ____
   ____
   How long have you had this problem?____
3. ____
   ____
   How long have you had this problem?____

Have you been given a diagnosis for these problems?____
What other treatments have you tried and what were the outcomes?_____________________________________
____
____

CHECK AND INDICATE THE AGE WHEN YOU HAD ANY OF THE FOLLOWING:

GENERAL

- ☐ Poor Appetite
- ☐ Hearing Loss
- ☐ Easy to Bleed or Bruise
- ☐ Strong Thirst
- ☐ Puffiness or Swelling
- ☐ Night Sweats
- ☐ Changes in Appetite
- ☐ Weakness
- ☐ Fevers
- ☐ Sweats Easily
- ☐ Poor Sleep
- ☐ Poor Balance
- ☐ Cravings
- ☐ Sudden Energy Drops
- ☐ Chills
- ☐ Fatigue
- ☐ Tremors
- ☐ Weight Loss
- ☐ Weight Gain

SKIN & HAIR

- ☐ Rashes
- ☐ Skin Ulcers
- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Dandruff
- ☐ Hair Loss
- ☐ Recent Moles

RESPITATORY

- ☐ Cough
- ☐ Phlegm
- ☐ Asthma
- ☐ Bronchitis
- ☐ Coughing up Blood
- ☐ Painful Breathing
- ☐ Difficulty Breathing
- ☐ Pneumonia
- ☐ Easily Winded

MUSCULO-SKELETAL

- ☐ Arthritis
- ☐ Muscle Spasms
- ☐ Pain and Weather Changes
- ☐ Muscle Weakness
- ☐ Scoliosis
- ☐ Pain with Activity
- ☐ Muscle Cramping
- ☐ Weak Joints
- ☐ Pain after Waking

HEAD, EYES, EARS, NOSE & THROAT

- ☐ Dizziness
- ☐ Cataracts
- ☐ Taste/smell problems
- ☐ Eye Strain/Pain
- ☐ Nose Bleeds
- ☐ Migraines
- ☐ Recurrent Sore Throat
- ☐ Toothache
- ☐ Ear Ringing
- ☐ Headaches
- ☐ Night Blindness
- ☐ Facial Pain
- ☐ Ear Aches
- ☐ Lip or Tongue Sores
- ☐ Blurry Vision
- ☐ Sinus Problems
- ☐ Concussions
- ☐ Poor Hearing
- ☐ TMJ Pain
- ☐ Spots in Front of Eyes
- ☐ Floaters

GASTRO-INTESTINAL

- ☐ Nausea
- ☐ Bad Breath
- ☐ Chronic Laxative Use
- ☐ Indigestion
- ☐ Blood in Stools
- ☐ Constipation
- ☐ Ulcers
- ☐ Vomiting
- ☐ Rectal Pain
- ☐ Hemorrhoids
- ☐ Diarrhea
- ☐ Abdominal Pain
- ☐ Intestinal Gas
- ☐ Belching

UROLOGY

- ☐ Painful Urination
- ☐ Decrease in Urine Flow
- ☐ Cloudy Urine
- ☐ Pain in Groin Area
- ☐ Urgency to Urinate
- ☐ Frequent Urination
- ☐ Kidney Stones
- ☐ Sexually Transmitted Disease
- ☐ Unable to Hold Urine
- ☐ Blood in Urine
- ☐ Frequent Night Urination

NEURO-PSYCHOLOGICAL

- ☐ Seizures
- ☐ Twitches
- ☐ Irritability
- ☐ Poor Memory
- ☐ Tremors
- ☐ Areas of Numbness
- ☐ Lack of Coordination
- ☐ Loss of Balance
- ☐ Anxiety
- ☐ Concussion
- ☐ Stress
- ☐ Mood Swings

GYNECOLOGY

- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Breast Lumps
- ☐ Spotting
- ☐ Vaginal Discharge
- ☐ Clots
- ☐ PMS
- ☐ Menopausal
- ☐ Yeast Infections
- ☐ Fertility Problems

Age of Menses__________

Duration of Menses______

____

Date of Last Menses ______

____

# of Pregnancies __________

# of Births _______________

Consent for care

I acknowledge that acupuncture is not a substitute for medical care, medical examination or diagnosis.
I have stated all my known medical conditions and I will inform my practitioner of any change in my health status. It is my choice to receive acupuncture, I am aware of the benefits and risks, and I give my consent for acupuncture. I understand that there is no implied or stated guarantee of success or effectiveness for acupuncture sessions. I understand that the client therapist relationship will be held in strict confidence.

Signature……………………………………………………………………………..Date…………………………………………………